The Universal Service Fund for Rural Health Care provides significant assistance in improving the quality and access of medical services provided to our citizens in Rural America.

RURAL AREAS Each year the program continues to improve. The modification of the definition for rural areas in the program will include more health care providers that had been excluded in the past. At the same time, maintaining the funding for health care providers in rural areas which have now been transitioned into urban areas. By using a grandfather clause, this allows additional time to review the impact on these hospitals.

I am concerned with locations being lumped into urban areas. The census based MSA and Micro-MSA serve a different primary purpose than rural health care. I'm not sure the impact of how MSAs are created based on ….. "having a high degree of social and economic interaction with the core as measured through commuting ties." Rural farm communities often need additional financial support from a spouse or children working for pay and benefits at nearby or not so nearby towns. I do have a concern that this need may be causing some locations to be excluded when in fact, they should qualify

I came across, three examples. The population number is based on the 2004 State Map provide by Wisconsin. Each has a local hospital.

Hudson; 8,775 & N Hudson: 3,463
River Falls: 12,560
Wisconsin Rapids: 18,435 & Port Edwards 1,944 & Nekoosa 2,590 & Biron: 915

Hudson and River Falls are near the Minnesota border near the Twin cities. Wisconsin Rapids is in Central Wisconsin. In the case of Wisconsin Rapids, to exceed the 25,000 population requirement you must add the populations of 4 towns spread along the Wisconsin River for over 16 miles. While the addition of population groups may be interesting, I'm not sure the census tracts size and shapes are true representations of the ability of a community hospital to financial survive. That is being an urban hospital.

466 CUT OFF DATE I agree with the ability to submit on line that the cutoff date should be June 30th. This will allow the packets for the next year to be processed earlier so the turn around time from initial submission to funding commitment is reduced.

REQUIRED TIME INVESTMENT The use of the e-forms for the 465, 466 and 467 have reduced the time required to request, document and certify services for support. However, significant time is also required on the back end to work with the carrier to confirm payments and verify payments have been provided.

In the first funding year, support was limited to a service; one location, one service, one FRN. Today, a location may have a dozen FRNs. But, carriers are not required to identify the credits provided on the bills with the Funding Request Number. Payments are often labeled as "Lump Sum Adjustment." Finding out the source of the funding adjustment can be very time consuming. The Lump Sum can apply to any type of credit correction not just the USF support. Credits may be placed on bills quickly or be delayed for several months.

I request the Commission to require carriers to identify USF payments on their billings or provide a separate confirmation via mail or e-mail to the HCP identifying the FRN number, payment amount and date of payment. This step will save staff time and improve confirmation of payments.

INTERNET SUPPORT The flat support for internet at 25% should be increased to 50% when used as a vehicle to provide a VPN type connection to other health providers. The internet has quickly become an economical way increase bandwidth beyond 64k. By creating a high speed connection to the net, other providers can be quickly be added without the need to establish separate independent point to point service. I strongly encourage the Commission to increase the support to 50%.

CONSTRUCTION SUPPORT The requirement for bandwidth continues to increase with the expansion of diagnostic services. Fractional T-1s and T-1s can not provide the bandwidth needed to support rural hospitals and clinics. Rural America is relying more and more on urban health professionals to review results from procedures and treatments. Telecommunications, high speed telecommunications, plays a critical role in transmitting the information quickly to specialists.

Telecommunications must be reliable, inexpensive, and scalable for future needs. Broadband cable providers can provide end to end support, is significantly less expensive per Megabit than traditional T-1s, and bandwidth can be increased quickly without the need for more investment in plant. However, broadband only covers a small portion of Rural America. The USF program should allow funds to be allocated to assist in the installation of inter city facilities when used to provide links to health care.

Once installed, these intercity facilities can and will most likely be used for other non USF users. I believe the USF should help pay for the installation of new facilities. As the cable company benefits by additional non-USF users, credits must be provided back to the fund or HCP. This would be based on the percentage of non-USF traffic on the facility, a credit would be applied to the contract price. This would allow hospitals sooner access to high speed telecommunication services while building long term value.

A: DS-3 at tariff rates of $20,000 / mo for 60 months [$1.2M]-or-
B: DS-3 single upfront payment for $600,000 and a monthly payment of $3000 with possible offsetting credit of $3000 per month.

The goal is to partner with telecommunication entities to build the best long term network for the health care providers. This might extend to assisting hospitals to build facilities to a meet point to access long haul intercity services.

Thanks you for the opportunity to share some concerns and ideas.

Michael O'Connor